Choices for Care

Program Application

Please Print Clearly

SECTION A: Individual Information

1. Name: _____ 2. ☐ Male ☐ Female
Last *First* *MI*

3. Address: _____
Street/RFD/Box *City/Town* *State* *Zip*

4. Phone: _____ 5. SS #: _____ 6. Date of Birth: ____/____/_____

7. Town where services will be provided, if different than current residence: _____

8. Currently at: ☐ Home ☐ Hospital ☐ Nursing Facility ☐ Residential Care Home/ALR
Name of facility: _____

SECTION B: Contact Information

1. Spouse/Partner (if any): _____
a. (Name) *b. (Phone)*

2. Primary Physician: _____
a. (Name) *b. (Phone)*

3. Other contact (family/friend): _____
a. (Name) *b. (Phone)*

4. Legal Representative (if any): _____ Phone: _____
Address: _____
Street/RFD/Box *City/Town* *State* *Zip*
* Type of legal representative: _____ ***(*Attach copy of documentation if available.)***

SECTION C: Choice of Care/Setting

1. Where do you (or legal representative) want to receive your long-term care services?
a. ☐ Own home/apartment c. ☐ Nursing Facility e. ☐ Hospital (Swing Bed only)
b. ☐ Home of another (family, friend) d. ☐ Enhanced Residential Care f. ☐ No preference

2. If other than "own home/apartment" indicate the name and phone number of the planned place of residence.
Name: _____ Phone number: _____

3. For Nursing Facility or Hospital Swing Bed, is the stay planned to be 30 days or less? ☐ Yes ☐ No

SECTION D: Health Benefits

1. Do you have any of the following health insurance benefits?

a. Medicare	☐ Yes	☐ No	☐ Don't know
b. VT Medicaid	☐ Yes	☐ No	☐ Don't know
c. VT Health Access Plan (VHAP)	☐ Yes	☐ No	☐ Don't know
d. Veterans (VA) Medical	☐ Yes	☐ No	☐ Don't know
e. Private Health Insurance	☐ Yes	☐ No	☐ Don't know

Mail to closest DAIL District Office. District Office addresses are provided on the last page of this form.

SECTION E: Risk Factors

Check **all** of the following that apply:

a. ☐ Multiple hospital admissions (3 or more) in last 6 months
b. ☐ Multiple Emergency Room visits (3 or more) in last 6 months
c. ☐ Fallen more than once in the last month. *Number of falls:*_____
d. ☐ Takes 5-7 prescription medications. *Number of medications:*_____
e. ☐ Takes 8 or more prescription medications. *Number of medications:*_____
f. ☐ Primary caregiver is expressing burnout or is at risk of imminent harm, ill health, or loss of job
g. ☐ Recent loss (past 3 months) of primary caregiver
h. ☐ No informal (unpaid) caregivers, such as family/friends
i. ☐ None of the above

SECTION F: Current Agency/Program Involvement

1. Check all agencies that you are currently involved with and indicate the name of the agency:

a. ☐ Area Agency on Aging: _____
b. ☐ Home Health Agency:_____
c. ☐ Adult Day Services:_____
d. ☐ Housing Authority: _____
e. ☐ Dept for Children and Families: _____
f. ☐ Mental Health Agency:_____
g. ☐ Other: _____
h. ☐ Don't Know

2. Check all home health services currently in place:

a. ☐ Home Health Aide (LNA)
b. ☐ Homemaker
c. ☐ Hospice Services
d. ☐ Nursing Services (RN)
e. ☐ Social Work Services
f. ☐ Therapy (check ☐ PT, ☐ OT, ☐ ST)
g. ☐ None of the above

3. Check all community-based programs that are currently in place:

a. ☐ Adult Day Services/Day Health Rehab
b. ☐ Attendant Services Program (PDAC)
c. ☐ Developmental Disability Services
d. ☐ Children's Personal Care Services
e. ☐ Medicaid High-Tech Services
f. ☐ Traumatic Brain Injury Waiver
g. ☐ Veterans Benefits/Services
h. ☐ Mental Health Services (CRT)
i. ☐ Other: _____
j. ☐ None of the above

SECTION G: Choice of Case Management Agency *(Home-Based and ERC settings only)*

For Home-Based and ERC settings, you must choose one of the below agencies to provide case management services. The case manager will assist with the eligibility process, ongoing assessment and coordination of long-term care services.

☐ Area Agency on Aging/Council on Aging ***-OR-*** ☐ Home Health Agency

SECTION H: Person/Agency Completing Form

Person Completing Form: _____

Agency Name: _____ Phone Number: _____

Address: _____

Signature: _____ Date: _____

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SECTION I: Health & Functional Assessment

Check the most recent type of health assessment available. **Include a copy with this application**.

☐ ILA (AAA, Adult Day) ☐ OASIS (Home Health Agency) ☐ Other: _____
☐ MDS (Nursing Facility) ☐ Resident Assessment (RCH/ALR) ☐ None

Comments (optional):

By signing this application form, the individual/legal representative agrees to the following statements:

- I wish to apply to the Choices for Care, Vermont Long-Term Care Medicaid program.
- I understand that I have the right to choose between long-term care settings.
- I understand that my name may be placed on a waiting list and I will be notified if this is the case.
- I agree to provide personal, medical and financial information to the persons who will determine my eligibility and provide services.
- I give permission for the referring agency (if applicable) to supply a copy of my recent health and functional assessment to the Department of Disabilities, Aging and Independent Living for the purpose of eligibility determination.
- I give permission for the Department of Disabilities, Aging and Independent Living staff to contact the facility I am currently at (if applicable), my legal representative and the agencies and medical providers I am currently involved with in order to determine eligibility and to eliminate duplication of effort.
- I understand that I must meet the general, clinical and financial eligibility criteria to be eligible for Choices for Care, VT Long-Term Care Medicaid services.
- I understand that I must apply for and be found eligible for VT Long-Term Care Medicaid financial eligibility through the local Department for Children and Families (DCF).
- I understand that if I am found eligible, I may be required to pay a portion of the cost of Choices for Care services, as determined by the Department for Children and Families (DCF).
- I understand that if I am found eligible, my clinical and financial eligibility will be periodically reassessed.
- I understand that if I am found eligible and receive Choices for Care services, under certain circumstances the Office of VT Health Access (OVHA) Estate Recovery Unit may recover the cost of providing these services from my estate. More information about Estate Recovery is available from DCF.
- I understand that if I receive Choices for Care services and am subsequently found clinically or financially ineligible, I will be required to pay for services provided.
- I understand that if found ineligible for Choices for Care services, I will be informed of my appeal rights.
- **To the best of my knowledge, the information on this form is correct.**

Applicant/Legal Representative_____ _____
Signature *Date*

Mail to closest DAIL District Office. District Office addresses are provided on the last page of this form.

Mail to: DAIL, Long-Term Care Clinical Coordinator *(address below)*

DAIL District Office	Address	Phone Number	FAX
Barre	Mcfarland State Office Building 5 Perry St., Suite 150 Barre, VT 05641	(802) 476-1646	(802) 476-1654
Bennington	200 Veterans' Memorial Drive, Suite 6 Bennington, VT 05201	(802) 447-2850	(802) 447-6972
Brattleboro	232 Main Street PO Box 70 Brattleboro, VT 05302-0070	(802) 251-2118	(802) 254-6394
Burlington	312 Hurricane Lane, Suite 201 Williston, VT 05495	(802) 879-5904	(802) 879-5620
Hartford	224 Holiday Drive, Suite A White River Junction, VT 05001-2097	(802) 296-5592	(802) 295-4148
Middlebury	700 Exchange Street, Suite 103 Middlebury, VT 05753	(802) 388-5730	(802) 388-4637
Morrisville	c/o DCF ESD P20 63 Professional Drive, Suite 4 Morrisville, VT 05661	(802) 888-0510	(802) 888-1345
Newport	100 Main St., Suite 240 Newport, VT 05855	(802) 334-3910	(802) 334-3386
Rutland	320 Asa Bloomer Building Rutland, VT 05701	(802) 786-5971	(802) 786-5882
Springfield	State Office Building/ESD 100 Mineral Street, Suite 201 Springfield, VT 05156	(802) 885-8875	(802) 885-8879
St. Albans	20 Houghton Street, Suite 313 St. Albans, VT 05478	(802) 524-7913	(802) 527-4078
St. Johnsbury	67 Eastern Ave, Suite 7 St. Johnsbury, VT 05819	(802) 748-8361	(802) 751-2644

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